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Collaborative public management: coordinated value propositions among public service organizations

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ABSTRACT

Drawing from collaborative public management, this article seeks to contribute to public service logic by focusing on what precedes the public service user's realization of value: the value proposition. A new care model for elderly people with multiple chronic diseases shows that coordinators with an inter-organizational mission, vertical and horizontal supporting structures, trust established through relationships, and recognition of service systems' embeddedness in social systems are pivotal for the ability of public service organizations to develop coordinated value propositions. The contribution to policy and practice is an increased understanding of a coherent, rather than fragmented, welfare system for users/citizens.

KEYWORDS Collaborative public management; public service logic; value proposition; service system; social system

Introduction

Many contemporary societies are, arguably, more interdependent and plural than ever before (Mintzberg 2015), not least because of globalization and technological advances, which makes such a society a 'polycentric, multi-nodal, multi-sector, multi-level, multi-actor, multi-logic, multi-media, multi-practice place' (Bryson et al. 2017, 641). Consequently, the challenges public service organizations (PSOs) face are increasingly complex, ambiguous, and uncertain, often addressing societal, even global, matters of concern (Bryson et al. 2017; Crosby, 'T Hart, and Torfing 2017). Commonly, these complex – or 'wicked' (Geuijen et al. 2017), or 'unruly' (Crosby, 'T Hart, and Torfing 2017) – challenges include issues that cut across boundaries, such as forced migration, climate change, poverty, terrorism, pandemics, or ageing societies (Christensen 2012; Crosby, 'T Hart, and Torfing 2017; Geuijen et al. 2017). Not only do problems like these share a level of complexity, but they also cannot be solved by the responsible PSO alone. Rather, they must be dealt with in an inter-organizational fashion (Crosby and Bryson 2005; Radnor et al. 2014; Torvinen and Haukipuro 2017).

The predominant *New Public Management* (NPM) reforms have often proved better suited for intra-organizational matters than in addressing complex issues

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(Alford 2016; Christensen and Lægreid 2011; Osborne 2018). More specifically, the 'production-esque' mode of NPM has emphasized the efficiency of internal processes' input and output (Osborne, Radnor, and Nasi 2013). Paired with NPM's decentralization of accountability, the focus has been on performance measures of delimited units *within* organizations (Andersson and Liff 2012), resulting in poor understanding of the whole system and, consequently, fragmented welfare services (Quist and Fransson 2014). In addition, the 'market-esque' mode of NPM has emphasized competition (Nordgren 2009), when collaboration between organizations are called for to address modern society's challenges (Osborne 2018). However, such collaboration meets many challenges (Lee and Lee 2018; Lucidarme, Cardon, and Willem 2016; Willem and Lucidarme 2014).

The collaborative approach of *public service logic* (PSL)[1] has been proposed to be an important equipoise to NPM's intra-organizational focus (Eriksson 2019; Osborne et al. 2015; Skålén et al. 2018). As revealed by the name, PSL borrows from service management (e.g. Grönroos 2011; Normann 2001) rather than the manufacturing industry from which many NPM ideas stem. By so doing, PSL moves beyond the single PSO to emphasise the broader service system by including a multiplicity of actors (Osborne, Radnor, and Strokosch 2016; Radnor et al. 2014). The collaborative public management literature (Agranoff and McGuire 2004; Blomgren Bingham, O'Leary, and Carlson 2008) and overlapping concepts (Bryson et al. 2017; Crosby, 'T Hart, and Torfing 2017) have highlighted aspects of *social* systems as important in collaborations. These are aspects that may have potential to inform PSL.

The empirical case in the present article describes a new and awarded care model for elderly with multiple chronic diseases that have shown remarkable results (an 80 per cent decrease in visits to the emergency rooms and a 92 per cent decrease in the number of days spent hospitalized for the patient group), from a previously fragmented and badly coordinated care between the three care organizations in the Swedish healthcare system. The article seeks to contribute to PSL by analysing the empirical case with social aspects of collaborative public management. More specifically, it focuses on value propositions – *potential* value, before the user realizes *real* value – a less developed aspect of PSL. The contribution to practice/policy is to highlight the potential to develop coordinated value propositions in order to overcome fragmented public services from the users'/citizens' perspective.

Collaboration as a post-NPM ideal

Increased collaboration among organizations is required to deal with the complex reality of today's societies (Christensen and Lægreid 2011; Pollitt 2003). Thus, the collaboration is not only needed to improve public services per se, but to create the capability of solving contemporary meta-problems of public sector service delivery (Keast and Brown 2002). The sheer numbers of emerging 'post-NPM' (Christensen 2012) concepts emphasizing the need for collaboration among PSOs and other actors consolidates the importance of organization beyond the 'inward-oriented culture and ways of operating' (Grönroos 2018, 2) or 'silo' approaches (Denhardt and Denhardt 2015; Osborne 2006; Pollitt 2003; Stoker 2006). In addition to concepts, practices have also seen an increase of such collaborations as a strategy to achieve collective impact (Berlin and Carlström 2015; Cristofoli, Meneguzzo, and Riccucci 2017; Koliba et al. 2017).

A commonality among many of the post-NPM concepts is the need to increase coordination as a response to counterbalance NPM's decentralization of accountability, which has often been blamed for fragmented public services (Andersson and Liff 2012; Christensen and Lægreid 2011). Such coordination is believed to improve how common resources are used (Meier and O'Toole 2003), for example, by sharing financial resources, information, and knowledge (Koliba et al. 2017), and improving service delivery for citizens and users (Meier and O'Toole 2003; Osborne 2006).

Because collaboration among PSOs is often informal and voluntary, it is important that PSOs perceive the participation as worthwhile (Koliba et al. 2017). An overriding reason to join or stay in collaborations may be that it is essential for achieving the results of the single PSO (Christensen and Lægreid 2015; Ferlie 2017) or in achieving common goals (Koliba et al. 2017; Willem and Lucidarme 2014). Collaborations can also nurture further collaborations; for instance, by working together organizations may learn from one another other, which may generate social capital and trust and may, in turn, generate a desire to develop collaborations, and so forth (Agranoff 2006; McGuire 2006; O'Leary and Vij 2012). Because of the believed benefits, '[t]he creation of "collaborative capabilities" has become as important as the departmental work upon which they were traditionally measured and evaluated' (Dudau and McAllister 2010, 400).

Naturally, there are various ways of collaborating in public management. Provan and Kenis (2008) differentiated between three models of network governance. First, in *shared governance*, networks are relatively informal and governance is decentralized by the participating organizsations managing both internal and external relationships together. Second, in *lead organization*, governance is more formalized and centralized than in the first model, and one organization is expected to take a leading role in managing networks. Third, in *network administrative organization*, formalization is the highest of the three models and a separate and centralized administrative entity is created to govern networks. Interaction of participating organizations in the first model is multilateral, but in the two latter models it is bilateral, occurring through the lead organization or the separate administrative entity, respectively. Power balance is rather asymmetric in the second model, in which power is concentrated on the lead organization, while in the other two models power is relatively symmetric among the networking organizations.

Public service logic: beyond introspective NPM

The developments of PSL have often argued against the manufacturing logic in which value is produced in sequential and predefined steps within a factory and delivered to a waiting customer (Osborne et al. 2015), a conception that builds on Porter's (1985) notion of the value chain model. Thus, NPM's focus on the organization's internal processes has not included the service user in the creation/production of value, nor other actors' contribution to the user's value creation process. Consequently, with each PSO focusing on their own internal efficiency, no actor takes responsibility for the whole, making the user's value creation suffer (Skålén 2016). Although often used interchangeably (Voorberg, Bekkers, and Tummers 2015), co-production emphasizes tangible resources, linearity, and the producer (Hardyman, Daunt, and Kitchener 2015; Osborne 2018) whereas co-creation 'assumes an interactive and dynamic relationship where value is created at the nexus of interaction' (Osborne 2018, 225). This also has consequences in how value is created (or produced), which will be elaborated in this section.

Value and value propositions

As an alternative to the value chain model, generic service management offers the value *star* model (Wikström and Normann 1992), in which value cannot be produced within a factory, but is rather to be considered to be co-created (Normann 2001). Because value is realized 'in-use' – when the user uses the service or product – the provider can only offer potential value, *value propositions* (Grönroos 2018; Vargo and Lusch 2008). Because service exchange is increasingly concerned with knowledge and information, as opposed to tangible resources, the collaborative value star should be more relevant than the linear value chain in most cases (Wikström and Normann 1992). The public service user may or may not translate propositions into real value during her or his usage, often by combining propositions separately provided to them by various sources (McColl-Kennedy et al. 2012). Because the provider cannot produce value, knowing how the user creates value becomes pivotal, including from whom propositions are integrated (Quist and Fransson 2014).

The concept of value propositions is emphasized also in the public management literature (Moore 1995). Here, value propositions are more similar to a focused mission statement addressing the public values that the PSO should produce, rather than the above service management focus on private value in which the user is the arbiter (Alford et al. 2017). The user is not excluded in Moore's (1995) public value, but rather than the user as the arbiter, the manager should seek authorization for the value proposition by users and other actors.

The inspiration from generic service logic's (Grönroos 2011; Vargo and Lusch 2008) notion of value is evident in early PSL (Osborne, Radnor, and Nasi 2013). In generic service logic, based on the private sector, value is often understood as subjective and individual (Grönroos 2011). Later, Alford (2016) suggested that the private and public sectors produce different things; where the former produces private value that directly benefits individual users, the latter produces public value that is supposed to benefit the collective citizenry. There may be a conflict between the individual service user's private value and the collective citizenry's public value regarding some public services, such as prison institutions (Moore 1995). Moreover, different PSOs may have conflicting public values that may complicate collaborative efforts (de Graaf and van der Wal 2008). The fact that value may not only be created, but also destructed, has also been recognized in PSL (Osborne 2018).

Requirements of public service logic in a collaborative public management setting

The service system is recognized in PSL (Osborne, Radnor, and Strokosch 2016; Radnor et al. 2014), but the social system (Edvardsson, Tronvoll, and Gruber 2011; Skålén 2016), framing the service system is not thoroughly elaborated. In this broadened service system, central are the 'processes by which value is created through interaction among multiple stakeholders' (Akaka, Vargo, and Lusch 2013, 7). However, in addition to multiple stakeholders, a service system embedded in social systems also acknowledges the impact of structures – formal and informal rules – on value co-creation (Edvardsson, Tronvoll, and Gruber 2011; Vargo and Akaka 2012). Thus, the actions and interactions of the actors in the system both influence and are influenced by these structures (Akaka, Vargo, and Lusch 2013; Vargo and Akaka

2012; Vargo and Lusch 2016); the structures are important drivers of interactions that may enable collaboration and value co-creation (Vargo and Akaka 2012; Vargo and Lusch 2016) but may also constrain such efforts and contribute to value destruction (Skålén 2016).

Similarly, the value star model recognizes that multiple actors' contributions are important, but still reveal little about these actors' relationships because their various propositions are *separately* provided to the user by PSOs and other actors. Thus, the complexity of the service system is not fully recognized.

To achieve collaboration, coordination may be needed. Coordination may be provided by a provider acting as a value facilitator of the user's value-creation process (Grönroos 2011, 2018). In so doing, the provider must have a good understanding of the value creation from the user's perspective (Nordgren 2009). With such knowledge, the provider knows about what other actors are important to the user and may mobilize their resources in the service system to match the user's value creation process, and by so doing, *enabling* the value creation (Normann 2001). In sum, PSL offers promising potential to develop public management beyond the intra-organizational manufacturing logic of NPM. However, other than a multiplicity of collaborating actors, the social system in which these collaborations take place remain relatively unexplored; that is, *how* the joint efforts of actors occur in formulating value propositions to users. Here, collaborative public management may offer potential to develop PSL.

Collaborative public management's potential to develop public service logic

This section accounts for the collaborative public management literature (Agranoff 2006; McGuire 2006) and overlapping post-NPM concepts (Bryson et al. 2017; Crosby, 'T Hart, and Torfing 2017) with a focus on how they can enhance PSL by taking the social system into consideration. Their shared commonality is that coordination in the public sector is notoriously complex due to the magnitude of actors that need to collaborate and the interrelated potential for multiple and conflicting organizational and individual goals and priorities to arise (Cucciniello et al. 2015; Lægreid et al. 2015). Indeed, successful collaborations in terms of better use of resources and improved services are relatively rare (Hill and Lynn 2003). A probable reason for the lack of successful examples may be that collaborations have been evaluated based on traditional performance measures, whereas evaluations have neglected essential aspects of how collaborations are carried out, such as processes that forge, organize and sustain relationships (Mandell and Keast 2008).

How are collaborations carried out?

In collaborative public management, the complexity of challenges entails that single public managers cannot act as 'heroic strategists', but rather 'orchestrators of networked interaction and mutual learning' (Crosby, 'T Hart, and Torfing 2017, 656). It has been argued that too much focus in the public value management literature (Moore 1995) has been on single managers at the top of a single PSO (Bryson et al. 2017; Crosby, 'T Hart, and Torfing 2017). More specifically, in collaborative public management, 'integrative leadership' (Crosby and Bryson 2010) entails that public

managers' tasks should be to stimulate interaction and exchange of resources, including knowledge and skills, and to explore how a variety of actors could design joint value propositions with respect to an issue of common concern (Crosby, 'T Hart, and Torfing 2017). In later work, Moore (Moore and Hartley 2008) recognized collaborations among organizations and co-production with users/citizens to be important in practically producing the service. Moreover, it is argued that collaborations should start at the outset of the policy change cycle, not just in implementing new policies, projects, and programs (Crosby and Bryson 2005).

Elected officials or actors from other organizations without formal authority (rather than managers) are often expected to take lead, or at least support, public value creation (Bryson et al. 2017; Crosby, 'T Hart, and Torfing 2017). To Crosby, 'T Hart, and Torfing (2017), such 'distributed leadership' that takes place in networks or partnerships is essential for innovation in the public sector. These actors are increasingly conceptualized as network managers, despite their lack of traditional managerial authorities (Bartelings et al. 2017; Cristofoli, Macciò, and Pedrazzi 2015; Cristofoli, Meneguzzo, and Riccucci 2017; Edelenbos, van Buuren, and Klijn 2013). Typically, these actors are labelled as network facilitator, mediator, leader, or coordinator, but they are important in *managing* networks (Cristofoli, Macciò, and Pedrazzi 2015) through initiating and supporting interaction among members, solving and managing conflicts and changes, leading the network to its goal and mission, and building trust and commitment (Klijn, Steijn, and Edelenbos 2010). Edelenbos, van Buuren, and Klijn (2013) illustrate that connective capacities are essential for network managers, and that managers from the participating organizations often have problems beyond the value of their own organization, which is why other actors may take on such a role better.

Network managers' roles are important, not least because the participating organizations remain connected to their specific authorizing environment, and henceforth public value to be prioritized may differ between collaborating actors. They are both negotiating a shared goal as well as their own tasks and interests (Bryson et al. 2017). Moreover, cultures and laws differ and may impact collaboration (McGuire 2006; O'Leary and Vij 2012). Willem and Lucidarme (2014) found that flexibility is the main success factor of collaborative networks, but that this flexibility is constantly under pressure from bureaucratic structures of the participating organizations. Markovic (2017) further explained that networks that are organized around one focal organization tend to rely more on traditional managerial activities and control, whereas decentralized networks without a single 'ruling' organization tend to rely more on coordinating mechanisms than traditional managerial control.

Ideally, collaboration among multiple organizations should be informal, non-hierarchical networks of equal actors in which consensus is sought (McGuire 2006; O'Leary and Vij 2012). However, many scholars have theoretically addressed networks as informal and based on bottom-up processes as a point of departure, thereby empirically missing top-down network aspects (Span et al. 2012). The informal view also creates problems, because it is a frail way of organizing, dependent on individual enthusiasts, and the grade of commitment varies among the participating organizations. Moreover, participating actors may be unaccustomed to working informally and non-hierarchically. These collaborations are not only inter-organizational but also inter-*personal*, which means that often the actors around the table are not equal – they have different strengths such as power, mandate, and status (Agranoff 2006; McGuire 2006). These differences may be

a reason that miscommunication is the most common problem in collaborations (Dudau, Fischbacher-Smith, and McAllister 2016).

In sum, collaborative public management's elaborations on social systems have the potential to develop PSL by emphasizing the following five points: (1) orchestrating interactions, exchange and learning processes between actors rather than management performed by single managers in single PSOs; (2) the importance of persons being given mandate to lead collaborations (such as facilitators and meditators) – that is, distributed leadership rather than management; (3) managing collaborations is also about building and maintaining relations based on trust; (4) one ruling organization builds on traditional management control, whereas coordinating mechanism is key in decentralized collaborations; and (5) the informal nature of collaborations is important but also makes collaboration vulnerable, and that formal/top-down aspects of collaborations may be missed.

Method and setting

Data collection and analysis

This article builds on a case study of a previously performed action research project. Two of the authors of this article were involved in the action research project since the start in 2000 (Bradbury and Lifvergren 2016). The *a priori* knowledge (Alvesson and Kärreman 2007) of the authors involved in the action research project has been important for understanding the present case, including validation of events and access to data. The action research project was interactive and included managers and staff from the three concerned PSOs with a close relationship to the empirical material. The overall ambition of that study was to improve a healthcare service, in particular from a patient's perspective, avoiding older patients suffering from multiple diseases to face a fragmented healthcare system. The action research project took place between 2000 until 2012. Large amounts of data were collected and analysed during these 12 years, both qualitatively and quantitatively, including field notes, observations, individual interviews, focus group interviews, documents and reports, and data retrieved from patient databases and medical databases. Descriptions of experiences based on the action research project have been published elsewhere (Lifvergren, Docherty, and Shani 2011; Lifvergren et al. 2012).

The present article builds on the same case as in the above. However, the action research project acts as a background and setting in the present study, which focuses on the evaluation phase of the project. The research approach was abductive (Dubois and Gadde 2002) in that the three authors who were not involved in the action research project moved iteratively between theory and the empirical material. The empirical material additional to the action research project was collected mainly from three sources: (1) seven semi structured and individual interviews with managers, healthcare staff 'in the field' and coordinators; (2) observations and field notes from meeting attendances; and (3) archival data of the project, including plans, presentations, and assessments. The three data sources were used for triangulation (Jick 1979) and to jointly create a holistic understanding of the studied case. Observations were done to observe interaction among participants and to identify interviewees and relevant topics about which to deepen understanding. Archival data were used to familiarize with the project and context, and interviews were used to understand the project and collaboration from the interviewees' respective roles and professions.

The duration of the interviews varied between 1 and 2 hours and was recorded. Participants were selected to cover persons who had been involved in the project for a long time. The interviews included questions about the patient group, how the current collaborative model was designed, and experiences of working in a collaborative fashion and in patients' homes. The literature of collaborative public management addressing social context was mainly used to guide questions to be asked during interviews and aspects particularly relevant to observe in meetings. However, the collection of empirical material required us to return to the theory that generated new questions to be asked in the subsequent interviews.

The overall empirical material was analysed in accordance with Miles and Huberman's (1994) three steps: reducing data, displaying data, and drawing conclusions. In reducing data, the empirical material was categorized into themes based on commonalities (Graneheim and Lundman 2004), as presented by the headings in the findings section. These categories are presented in relative concordance with the case's chronology. In displaying data, the themes were related to previous research mainly on collaborative public management and, to a lesser extent, PSL and contributed to our second-order concepts. In the final step, the empirical material was re-read and evidence of the concepts were sought for (Silverman 2001) and categorized as presented in the discussion section: the first concept is a reaction to symptoms (coordinators and supporting structures), the second and third concepts emphasize *how* they collaborate (trust, relationships and social systems), and the fourth concept is a result of the whole (coordinated value propositions). The 'new' authors (focusing on the recent evaluation) separately analysed the data in each step and then discussed the compliance of the separate analysis. The analysis was largely consistent between the authors, and the inter-rater reliability was therefore considered high (Hartling et al. 2012). The analysis and concepts were then validated and refined in a dialogue with the two action researchers who had long-term involvement in the empirical case.

Setting

In response to the lack of holism and systems view, local public service integration – or 'services-as-a-system' – by providers responsible for health and social care to older citizens has been called for (Laitinen, Kinder, and Stenvall 2018). This article addresses the complex issue of providing care to the elderly with multiple chronic diseases in a fragmented healthcare system. The Swedish healthcare system is divided into three administrative levels, all of which are governed by elected politicians: national government, regions (also called 'county councils'), and municipalities. Older patients with multiple chronic diseases often consume care at all three levels – care that has been poorly coordinated between the three caregivers. In the present case, management and staff representing the municipalities, the primary care units, and a local hospital jointly developed a new healthcare model that has shown remarkable results by emphasizing collaboration and addressing the patients' holistic needs.

As Swedish and other societies demographical structure is ageing, the number of elderly patients suffering from multiple and chronic diseases increases (WHO 2015). In the Swedish decentralized healthcare system, this patient group has, since a reform in 1992, been the shared responsibility of regions and municipalities. The Health and

Medical Act (SFS 2017) stipulates that the regions are responsible for providing healthcare, for example, by offering primary care and specialized hospital care, whereas municipalities are responsible for caring for the elderly in special accommodations or in their homes. In addition, the national government is responsible for legislation and for establishing principles and guidelines, the latter often through national agencies (SKL 2018). A lacking systems view has also been argued to be a consequence of NPM's decentralization of accountability that has created a fragmented healthcare service that is poorly coordinated for the increasing older population and their relatives (Skålén 2016).

Geographically, the study is set in a sparsely populated area covered by five municipalities in the Western Region of Sweden. The five municipalities have approximately 75,000 citizens in total, whereas the region inhabits 1,7 of Sweden's 10,1 million citizens (Statistics Sweden 2018). In the present case, management and co-workers from the five municipalities, 10 primary care units and the local hospital started to collaborate in 2001 to address the shortcomings of the fragmented healthcare systems due to reforms in the 1990s. Focus shifted from curing disease to addressing health maintenance, for older patients suffering from chronic and multiple illnesses.

Since 2008, staff from hospitals and municipalities have collaboratively treated patients with complex needs who fulfil certain criteria in their homes. It was decided that at least four of the following six criteria should be met in order for a patient to be treated within the new model: (1) have had at least three hospital admissions in the last 12 months; (2) have at least three chronic diseases; (3) have more than six standing medications; (4) require healthcare at home; (5) be at least 75 years of age; and (6) be dependent on activities of daily life. Practically, a physician and a nurse from the hospitals visit patients at their homes, where the municipalities' nurses and nurse assistants have had a long tradition of working. In 2012, two other teams were established. One team consisted of a physician from primary care, who visited patients at their homes, those who were too sick to return to ordinary primary care but too well to stay with the first team. A third team consisted of staff from the hospitals' palliative care.

Staff from the municipality constitute the steady party that mainly stays at the patients' homes (or they are 'the spine – neither of the three teams could manage without them', as mentioned by a hospital physician). Most commonly, the municipality nurses initiate that a certain patient is in need of the first team's services. In the two latter teams, commonly hospital staff are the ones writing a referral. The focus in this article is the first team, but as will be elaborated, the network should not be restricted to any of the teams.

The present project had gained a lot of national attention, not least because of the remarkable results reported. In a national inquiry (SOU 2016), the case was presented as a one of few concrete examples of 'efficient healthcare'. Since the start in 2001, there had been an 80 per cent decrease in visits to the emergency rooms and a 92 per cent decrease in days spent hospitalized for the patient group. Project management also measured patient satisfaction and could report that the team-based model at patients' homes was positively perceived by patients, for example, those who experienced more safety than being treated at a hospital. As mentioned by one physician, most patients wanted to stay as long as possible at home. Relatives also held positive experiences, for example, relatives said that it had been a relief not to be the ones deciding whether or not to take their family

members to the hospital or a primary care unit. Not only could positive results be reported on patient/relative level, but all interviewees mentioned that there were most likely gains on a societal level too by resources being used more adequately (Bradbury and Lifvergren 2016).

Findings

Developing relationships, principles, and trust

In the first years of the project, collaboration among the three parties was described as 'higgledy-piggledy' and mainly concerned information transfer, discussions of organizational boundaries and responsibilities and often involved 'blame games'. One interviewee recalled that the messiness and unclearness somehow allowed for gradual development of a joint understanding of important principles and values in the project, but also to sort out concrete issues such as economy. Slowly, relationships were established, and trust gained for one another. Another interviewee mentioned that once relationships started to be established, 'things got much smother' and parties could 'start to work together to solve real problems'. Another interviewee recalled that a few years into the project the interviewee had been 'on the verge of divorce', then decided to do a 'retake' on the collaboration. Particularly important in this retake was the joint work with a balanced scorecard that 'everybody used back then'. The process focused less on the actual scorecard, but more on the emerging principles important for the involved actors. The shared principles included concepts 'togetherness', that they were in this together; 'generosity', that it was important to share resources with one another; and 'trust', that management should not 'interfere with the process – but to trust the professionals on the floor – they know how to do things.'

Another emerging principle was patient-centredness that helped to shift focus from organization to patient. An important turning point in this shift had been the mapping of the process from the patient's perspective in which representatives from all three organizations could see and discuss the whole patient journey. By mapping the patient process, the representatives realized how little they saw and knew about the patients by focusing on only the part of the process within one's own organization. The patient focus meant that the patients' needs were central rather than organizational needs. This was achieved by focusing on the patient-staff meeting in which the specific needs and expectations of the patient in front of staff were pivotal to listen to. More specifically, patients and relatives were more involved than before in planning their own medical plan.

Senior representatives had been invited to share their experiences. However, their representation of older patients with multiple diseases could be questioned, argued some interviewees, not least because they were relatively healthy elderly people. In addition, the representatives sometimes lacked important local knowledge because they represented a larger geographical level. More recently, a physician had interviewed patients and relatives, and it had been clear that the transitions between the three organizations remained an issue for patients. Moreover, it was found that patients relevant for the team were often identified rather late in the process and that they often had been 'spinning around the healthcare carousel for a long time' before being enrolled with the team. The large staff turnover at municipality level

contributed to that because the newly recruited staff were often unaware of the teams' existence.

With the success and attention, there had been various initiatives to spread the model geographically within the region and to other parts of Sweden, but also to other patient groups. In sharing their experiences, the involved actors in 'the original project' had met large amounts of actors in recent years. However, as explained by an interviewed manager from the municipalities, those interested in the model did 'not want to hear about the shared organizational culture that took us almost 20 years to develop – they want it to be quicker'.

Making collaboration work

One manager expressed that it was particularly important to address shared principles when there were staff who were evidently 'not onboard', to 'clearly explain why we do things the way we do,' as one manager expressed. During the project, they had realized that besides the shared principles, having clear plans and goals for what one wanted to achieve was important. In following up plans and goals, to measure change quantitatively had been important, but equally important had been to 'measure the right things without increasing the burden of those working on the field'.

Collaboration, rather than formal networks, was believed to be constituted of relationships and shared principles, according to many interviewees. A coordinator mentioned that it was in a meeting and talking to each other that understanding of the other (person and organization) were created, and people stopped guarding their own organizational boundaries, such as economic matters. A physician mentioned that in the team, 'the network is the relationships – that is what makes it work [. . .] it's about giving and taking, drink coffee together'. However, another physician said that as a physician the work was rather lonely and 'one does not become part of the gang [. . .] and the nurses have their shared things'. This loneliness also included that, different to clinics, one had no colleagues to discuss things with at patients' homes, and one could not take various tests because there was no equipment. The backside of building the collaboration on relationships was that replacing staff, leaving, taking a vacation was difficult. A word used by three of the interviewees was to 'vaccinate' newly employed staff in 'this way of working together'.

The three organizations brought and received rather different kinds of knowledge to the network. The municipalities gained medical knowledge from the physicians. A current trend in regional healthcare was person-centred work, or seeing beyond the disease to the whole person, but this approach was not news for municipalities' nurses and nurse assistants, who had worked at patients' homes before the project: '. . . they have always worked like that', as told by a coordinator. Thus, municipality staff could provide knowledge of the patient's situation, a wider perspective than the diagnosis. Indeed, staff from primary care and hospitals were often not used to working at patients' homes, and the obligations and mandates one had within the walls of a traditional healthcare facility were not there – one had to re-learn how things were done. A physician stressed the importance of getting the municipality staff's 'home-knowledge' into the equation: '. . . in their homes, one understands the medical consequences in the patient's everyday life'.

A role recurrently mentioned as important in the collaborations was that of the coordinators. Practically, the coordinators had been the ones who led the work with shared principles and 'in keeping the network together'. Rather than focusing on the

process, the coordinators arranged meetings, among other things. They were part of the management network as well as present 'on the field a lot'. The coordinators themselves explained their role as being 'motivators', 'to provide support', 'facilitators', 'conflict solvers', 'mentors', and as 'guards' and 'bearers' of the shared organizational culture. The characteristics of a good coordinator was explained to include such as being good at 'implementing', 'follow up things', 'be an engine in the work', 'to like improvement work', 'good at initiating things and local improvements', 'work systematically' and 'to be used to talk in front of a group of people'. A manager explained the coordinators as 'the bridge between the management group and the teams', and the managers' 'extended arm.'

The coordinators came from one of the three organizations. While some coordinators said they did represent all three organizations, others said that they brought 'different things to the table depending on what organization they originally come from' and that they in that sense mainly represented that particular organization. The *a priori* knowledge from the original organization was used as a resource in working in the network, another said, and that access was much easier to the 'mother organization'. However, it was considered important to visit 'the others' organizations so that they would 'feel that we do not belong to a particular organization'. It was considered important that the coordinators focused on the big picture rather than organizational boundaries. The coordinators met on a regular basis in order to support one another. Some previous coordinators had not worked because 'they had had a problem to see the big picture and had focused more on their original organization'.

Of the three organizations, primary care had been the most difficult to involve. A recurring reason for this was that primary care was not as used as municipality or hospital to focus on one specific patient group, but rather 'to have patients between 0 and 100 years of age and all possible diseases there are…' However, collaboration with primary care had not been an issue when the project started, a manager recalled. A reason for the current issues could be deducted to the re-organization of primary care a couple of years into the project in which citizens were given the possibility to choose their primary care unit. This re-organization caused an increase in the number of primary care units, introduced private alternatives, and increased competition between units. Before there had been one primary care manager mandated to represent all units at different meetings, but since the re-organization, the separate units had been 'living their own lives – particularly the private ones – and had difficulties speaking with one voice' and with no shared resources to bring to the network. At the same time, primary care representatives had been 'increasingly worried about what would happen with their resources, which had made the whole network to wobble'. Because of the competition, primary care more than municipalities and hospitals acted based on various measurements. Thus, the reimbursement system for primary care 'put focus on how can a primary care unit gain revenue, rather than focusing on how to improve situations for patients', something that had complicated collaboration within the network. Some adjustments of reimbursements had been made but were believed to be insufficient. Rather, more formalized collaboration could be necessary to get primary care on board again, maybe by merging the three organizations into one, as explicitly suggested by three of the interviewees.

The collaboration: a network of networks

In order to make the teams function and to avoid discussions about boundaries and resources, there were two formal networks: the learning network, in which mainly co-workers met, and the management network, represented by managers and politicians. The coordinators participated in both these networks.

The learning networks occurred twice a year and involved mainly staff at 'floor level' from the three organizations and the coordinators. These networks were mentioned by the coordinators to be important for spreading and maintenance of the developed shared culture and creating a feeling of 'us' among the participants. Moreover, problems in the teams or at patients' homes were identified and discussed and brought by the coordinators to the management network, who had to 'deal with them'. Patient cases and patient needs were discussed in these meetings too, in which it was 'not allowed to talk boundaries' that had anything to do with economy, tradition, laws/rules, or professions. It was the coordinators' responsibility not to talk about such boundaries and to set the agenda for these meetings.

In parallel with the shift from organizational to patient focus, the management network had gradually shifted from consultative to operational function. At the same time, they made sure participants were managers with mandate, who could achieve things by freeing resources for the teams. At the management network meetings, they discussed shared areas in need of improvement and focused on learning from each other. Similar to the learning networks, they did not talk boundaries and were even prohibited to talk about economy: '… as soon as you stop talking about money, you start to save money,' according to a manager representing the municipalities. In the management network, the coordinators were responsible for setting the agenda for meetings and following up on those things happened.

Many of the interviewees talked about the importance of the interconnectedness of the three formal networks: the teams, the learning networks, and the management networks. Interconnectedness was important to make all three networks function optimally, and key was that the shared principles were present and discussed.

Discussion

Inter-organizational coordinators and supporting structures

As seen in the findings, shared principles were important in the collaborations. However, these neither occur nor are maintained by themselves. Indeed, private sector networks are maintained because of the economic benefit they bring to the participating players (Stabell and Fjeldstad 1998), but in public sector, this should not be likely to be considered a driving force for collaboration.

Thus, it seems that some kind of outer facilitating function – or 'backbone support' (Koliba et al. 2017) – is necessary in order to keep the network together. The collaborations – the teams around the patients – in the empirical case needed to be held together both horizontally in the co-workers' learning networks as well as vertically in the management network. In the provided case, the coordinators held the collaborations together both horizontally and vertically. To Grönroos (2008, 2011), one organization can take the lead in facilitating various organizations' value co-creation. However, as was the case with the coordinators, the facilitators may have an inter-organizational mission

in facilitating value co-creation. However, to balance representing one's own original organization and the network in a broader sense was rather difficult for the coordinators (Edelenbos, van Buuren, and Klijn 2013). Yet, this 'ambidextrousity' was essential in carrying out the coordinating role satisfyingly.

Not only the above balancing act but also the coordinators' lack of formal authority may constitute a challenge in leading collaborations in the public sector (Bartelings et al. 2017; Cristofoli, Macciò, and Pedrazzi 2015; Cristofoli, Meneguzzo, and Riccucci 2017; Edelenbos, van Buuren, and Klijn 2013). Nevertheless, the coordinators initiated and supported interaction among members, solved and managed conflicts and changes, built trust, and led the network to its goal and mission (Klijn, Steijn, and Edelenbos 2010). Indeed, in the provided case, maintaining the shared principles was a major task of the coordinators. The coordinators were also responsible for making sure the different PSOs did not focus on their own economy and boundaries and so forth, but rather on sharing resources, information, expertise, and so forth (Koliba et al. 2017). This was important because each actor – despite their interconnectedness – always remained connected to their environment; public values between PSOs therefore may differ (Bryson et al. 2017).

In a sense, collaboration was not equal in that respondents clearly perceived the municipalities to constitute the main organization ('the spine', as expressed by a physician). However, there was nothing suggesting that this 'spine' caused the collaboration to rely more on traditional managerial control more than decentralized networks' focus on coordinating mechanisms (Markovic 2017). The present case revealed that management had increasingly focused on supporting staff at patients' homes rather than controlling them. This may be a parallel development to the increased trust in the project that was developed first after many years. Previous studies have shown that more short-term relationships, the higher degree of top-down mechanisms and higher trust in relationships increases the bottom-up mechanisms in the network (e.g., Lucidarme, Cardon, and Willem 2016; Markovic 2017; Span et al. 2012; Willem and Lucidarme 2014).

Trust: derived and maintained in relationships

As mentioned by the participants who had been involved since the beginning, it was not until shared principles were discussed that collaboration started to function. For example, patient focus proved important as a shared and guiding principle. Through established relationships, the different organizations and professions gained increased mutual understanding, enabling collaboration. Also in the teams around the patient, it was evident that relationships were crucial. Indeed, the relationship is what was considered to constitute the actual network in the teams. However, collaborations are not just inter-organizational but also inter-*personal*, and therefore the individuals bring different mandates and status to the collaboration (Agranoff 2006; McGuire 2006; O'Leary and Vij 2012). For example, one physician mentioned that being 'part of the gang' with the nurses was not a matter of course. Thus, formal and informal rules affect interaction among actors, including the patients.

Moreover, the reason for the PSOs in the present case to join and stay in the collaboration was largely by focusing on common goals (Koliba et al. 2017; Willem and Lucidarme 2014), such as the shared principles. Indeed, the interviewees took pride in saying that discussing boundaries and intra-organizational matters was not allowed. It was not elaborated in the empirical findings, but the lack of obvious

benefit and value for the single PSO by collaborating may cause difficulties in the long run (Koliba et al. 2017). What was mentioned was a negative example only, in which primary care reform had entailed more focus on economic revenue for the particular unit. What the example also showed was the importance of collaboration to be flexible to deal and handle such outer changes (Willem and Lucidarme 2014).

Overall, trust achieved through relationships proved pivotal in making the different actors working together (Lucidarme, Cardon, and Willem 2016; Mandell and Keast 2008; Markovic 2017; Span et al. 2012; Willem and Lucidarme 2014). However, developing trust is likely to take time.

The service system embedded in social systems

As a consequence of the Swedish decentralized healthcare system, three organizations are commonly directly involved for the patient group in the provided case: the municipality, primary care, and hospital care. The fragmented service system was one reason why more profound collaborations were initiated. Thus, in the provided empirical case, the value chain (Porter 1985) is an inappropriate model in understanding the present case and similar collaborative initiatives, not least because value is not produced within one organization. On the contrary, PSL emphasizes the service system rather than the discrete provider-user transaction in isolation (Osborne, Radnor, and Strokosch 2016; Radnor et al. 2014). Consequently, the contribution of a multiplicity of actors in value co-creation is recognized (Osborne 2018).

What is not as elaborated in PSL is the *social* systems in which service systems are embedded (Edvardsson, Tronvoll, and Gruber 2011). As seen in the empirical findings, the healthcare service system is not embedded in one social system, but rather a number of overlapping social systems (Skålén 2016) in which different organizations and professions may bring various (in)formal rules and norms to the table. Of course, many of these rules and norms may be in conflict, making collaboration difficult, at least initially. As seen in the empirical case, the three players did not initially communicate – they guarded boundaries and blamed one another. Similarly, in collaborative public management literature, Provan, Kenis, and Human (2008) have highlighted that, particularly in the early phases of collaboration, legitimacy building is critical for successful organizational networks.

In understanding the value co-creation processes that take place among multiple actors it becomes crucial to recognize and consider social forces' impact on interactions and actions taking place (or not) between actors in the service system (Akaka, Vargo, and Lusch 2013). These social forces or structures may be explained as guiding formal and informal rules, as in *enabling* and *constraining* collaborations in creating value among actors (Edvardsson, Tronvoll, and Gruber 2011; Eriksson 2019).

Coordinated value propositions

As mentioned, there is a need for increased understanding of developing existing – or creating new – value propositions in PSL (Osborne 2018; Skålén et al. 2018), not least propositions created jointly among multiple, rather than single, PSOs (Bryson et al. 2017). Rather than separate, or discrete, value propositions by the PSOs, suggested by the value star model, organizations could find ways to work together to develop joint value propositions based on the needs of the service user (or patient *group*, as in the provided

case). In the present case, one coordinated value proposition, rather than three separate, were offered to the user by the municipality, primary care, and hospital. Such a proposition *enables* the value creation for the user if it is truly organized to support the patient's value-creation process and if the proposition is developed with knowledge of *where* patients create value-in-use – at their homes. The empirical case emphasizes the importance of the municipality staff's knowledge about patients' broader life situations. This is knowledge that traditional healthcare providers cannot gain, because these propositions are commonly offered at places remote from the patients' homes.

Again, the shared principles, such as focusing on patient rather than organization, may have been an important factor in getting all three parties to work together. Naturally, here too the coordinators were important in the coordinated value proposition. As seen in Figure 1, the three organizations' propositions are coordinated to one joint proposition provided at the patients' homes. On the right-hand side, examples of other actors' propositions are exemplified. Clearly, rather than competition of NPM, collaboration should be central in value co-creation (Vargo and Lusch 2016). However, as seen in the case, aspects important in collaborations – for example, establishing relationships and shared principles – is not an easy task and will likely be affected by various social systems, or changes in them, for example, in primary care reform. Consequently, a systems view should not be restricted to include knowledge of what other actors' resources to mobilize in order to best support the user's value-creation process, but also to be aware of, for example, organizational cultures or power asymmetries between professions that is pivotal for collaborative efforts and establishing relationships.

The benefit of a joint proposition is not only from the patient's perspective in meeting a less fragmented healthcare system. Also, the PSO may benefit from sharing and coordinating resources with other PSOs (Meier and O'Toole 2003). Moreover, the benefit is also for the broader citizenry in that public resources are used more accurately (Alford 2016; Stoker 2006). As such, the empirical case mainly bears similarities with the network administrative organization of Provan and Kenis' (2008), particularly because of the coordinators' central role as an entity. In this model of network governance, the coordinators – or 'network managers' (Cristofoli, Meneguzzo, and Riccucci 2017; Edelenbos, van Buuren, and Klijn 2013) – constitute the central administrative function. In the other models, their role would not be as essential because of the informal nature of one of the models, and the leading organization in the other model (Provan and Kenis 2008).

Finally, the developed principles in the empirical material are similar to some public values as identified in Jørgensen and Bozeman's (2007) inventory: togetherness and generosity relate to the public value of cooperativeness; trust to professionalism; and patient-centredness to user orientation. Consequently, these principles – or public values – were important not only to make collaboration easier by focusing on commonalities rather

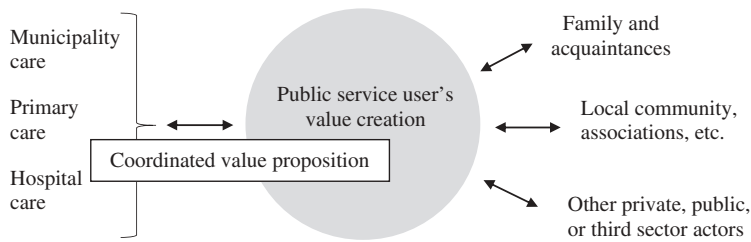

Figure 1. Coordinated value proposition.

than differences (Koliba et al. 2017) but were also embedded in the joint value proposition with the purpose of enabling the individual patient's value creation. Thus, coordinated value propositions of PSL may link public and private value (Eriksson and Nordgren 2018). Public values may be the public sector equivalent of the private sector's profit incentive for collaborating in networks (Stabell and Fjeldstad 1998).

Conclusion

As the challenges that many PSOs face become increasingly complex, the worse the fit of management ideas entailing an intra-organizational focus, such as in many NPM ideas. PSL offers a promising alternative in that the collaborative fashion of multiplicity of actors' contribution to the public service user's value creation is acknowledged. In addition, what happens to the user becomes central, not what happens within the PSO's internal processes. By drawing from collaborative public management literature – and especially aspects of social systems – the article contributes to PSL by focusing on a less elaborated activity: value propositions that precede the user's value creation. More concretely, the article contributes to PSL in four ways. Firstly, it highlights the importance of a coordinating function and supporting structures to hold the collaboration together. Secondly, it addresses the fact that difficulties in collaborating may be overcome through mutual trust that derives from and is maintained in relationships between the collaborative parties, although it may take time to establish trust. Thirdly, the article recognizes that the service system – care for the elderly, as in the present case – is always embedded in multiple social systems that entail that actors bring various rules and norms to the table. Finally, by emphasizing the importance of the three preceding points, 'siloisation' may be hindered by collaborating in developing joint and coordinated value proposition. The coordinated proposition needs to stem from knowledge of where the patient creates value-in-use, or realizes value – in their homes, in the present case. The contribution to practice and policy is to increase understanding of how PSOs may work together to address complex challenges, such as those caused by ageing societies, and by so doing overcome fragmentation by offering coherent welfare services to users/citizens. Focus on shared public values – such as the principle 'patient-cent redness' – may quicken relationship-building and, as a consequence, successful collaborations.

The centrality of the user/citizen is pivotal in PSL. Thus, including the user in data collection should be important. However, the focus in this article is on the value *proposition*, and therefore collecting such data was not considered necessary. However, co-production (or 'co-design' [Osborne, Radnor, and Strokosch 2016]) with users/citizens of the actual service is highlighted in public value management literature (Moore and Hartley 2008) and some of the collaborative public management literature (Cooper, Bryer, and Meek 2008) address the user/citizen as a particularly important actor in collaborations. Users/citizens could not only be part of collaboration concerning existing services, but also for new services or whole service systems, as co-constructionists and co-innovators, respectively (Osborne, Radnor, and Strokosch 2016). Thus, future research could investigate the potential contribution of the user/citizen in collaborations, including developing joint value propositions. Furthermore, traditional performance measures are argued to be ill-fit for evaluating collaborative public management. Rather, the processes of organizing and sustaining relationships should be central (Mandell and Keast 2008). Future empirical research could investigate how the relational aspect could be evaluated in such collaborative efforts.

Note

1. In Osborne (2018) a shift from public service-dominant logic (PSDL) to PSL was suggested, borrowing mainly from a service logic (Grönroos 2018) rather than a service-dominant logic (Vargo and Lusch 2016). For the purpose of this article, a distinction between the concepts is not necessary and PSDL is considered to be framed by PSL.

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